No. 80-5303

MICHAEL RO

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

ANTONIA BELTRAN, INDIVIDUALLY AND ON BEHALF OF ALL OTHERS SIMILARLY SITUATED,

Petitioner,

v.

BEVERLEE A. MYERS, INDIVIDUALLY AND AS DIRECTOR, CALIFORNIA STATE DEPARTMENT OF HEALTH; AND ELISABETH LYMAN, INDIVIDUALLY AND AS DEPUTY DIRECTOR, CALIFORNIA STATE DEPARTMENT OF HEALTH,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE PETITIONER

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QUESTION PRESENTED

Whether the application by California of a "transfer of assets" rule to its medically needy aged, blind, and disabled applicants for, and recipients of, Medicaid, resulting in the denial of assistance to individuals otherwise eligible, violates the applicable portions of the Social Security Act and thus the Supremacy Clause.

LIST OF PARTIES

Petitioner: Antonia Beltran
Respondents: Beverlee A. Myers and Elisabeth Lyman

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	iii
OPINIONS BELOW	1
JURISDICTION	2
STATUTORY AND REGULATORY PROVISIONS INVOLVED	2
STATEMENT OF THE CASE	2
SUMMARY OF ARGUMENT	11
ARGUMENT	15
SINCE THE SSI STATUTE PROHIBITS APPLYING TRANSFER OF ASSETS RULES TO SSI APPLICANTS, STATES ARE FORBIDDEN TO CONSIDER TRANSFERS IN DETERMINING ELIGIBILITY OF THE MEDICALLY NEEDY IN "SSI" STATES	15
A. Transfer rules cannot be applied in SSI states to determine eligibility for the categorically needy aged, blind and disabled	15
B. The "comparability" requirements of the Medicaid statute preclude applying more restrictive rules to the medically needy than to the categorically needy	17
C. The federal prohibition against transfer rules reflects a policy decision that these rules are inappropriate	29
D. While California has many options, its participation in the federal Medicaid program precludes it from employing a provision which violates federal law	34
CONCLUSION	36

TABLE OF AUTHORITIES

Page

Cases:

Aitchison v. Berger,
404 F.Supp. 1137 (S.D.N.Y. 1975), *aff'd without opinion* 538 F.2d 307 (2d Cir.), *cert. denied* 429 U.S. 890 (1976)..... 26, 27

Anson v. Kitchin,
64 A.D.2d 752, 406 N.Y.S.2d 916 (3d Dept. 1978)..... 33

Banco Nacional de Cuba v. Farr,
383 F.2d 166 (2d Cir. 1967), *cert. denied* 390 U.S. 956 (1968)..... 29

Beal v. Doe,
432 U.S. 438 (1977)..... 5, 16

Blum v. Caldwell,
____ U.S. ____, 100 S.Ct. 1635 (Mr. Justice Marshall, in chambers, 1980)..... 16, 26

Buckner v. Maher,
424 F.Supp. 366 (D.Conn. 1976), *aff'd* 434 U.S. 898 (1977)..... 29

Caldwell v. Blum,
CCH Medicare & Medicaid Guide, ¶30,093 (N.D.N.Y. 1979), *aff'd* 621 F.2d 491 (2d Cir. 1980)..... 26, 33

Caldwell v. Blum,
621 F.2d 491 (2d Cir. 1980), *pet. for cert. pending* No. 79-2034 (filed June 24, 1980)..... *passim*

Caldwell v. Blum,
No. 78-CV-569 (N.D.N.Y., Nov. 4, 1980)..... 29, 36

Dawson v. Beach,
No. 78-2350 (C.D.Cal. 1979), *aff'd sub nom. Dawson v. Myers,* 622 F.2d 1304 (9th Cir. 1980)... 26

Dawson v. Myers,
622 F.2d 1304 (9th Cir. 1980)..... *passim*

Dominguez v. Milliken,
CCH Medicare & Medicaid Guide, ¶26,633
(W.D.Mich. 1973)..... 26

Espinoza v. Farah Manufacturing Co.,
414 U.S. 86 (1973)..... 25

Fabula v. Buck,
598 F.2d 869 (4th Cir. 1979)..... *passim*

Fabula v. Solomon,
463 F.Supp. 830 (D.Md. 1978), *rev'd sub nom.*
Fabula v. Buck, 598 F.2d 869 (4th Cir. 1979).. 21, 26

Friedman v. Berger,
547 F.2d 724 (2d Cir. 1976), *cert. denied* 430
U.S. 984 (1977)..... 5, 26

Gardner v. Lavine,
56 A.D.2d 930, 393 N.Y.S.2d 51 (2d Dept.
1977)..... 33

Gray Panthers v. Administrator, Health Care
Financing Administration, 629 F.2d 180 (D.C.
Cir. 1980), *pet. for cert. pending sub nom. Harris*
v. Gray Panthers, No. 80-756 (filed Nov. 10,
1980)..... 4, 5

Greklek v. Toia,
565 F.2d 1259 (2d Cir. 1977), *cert. denied sub*
nom. Blum v. Toomey, 436 U.S. 962 (1978)..... 26

Harris v. McRae,
___ U.S. ___, 100 S.Ct. 2671 (1980)..... 3, 4, 16

Hendrickson v. Noot,
CCH Medicare & Medicaid Guide, ¶30,499
(D.Minn. 1980)..... 26

Herweg v. Ray,
619 F.2d 1265 (8th Cir. 1980), *pet. for cert.*
pending No. 80-60 (filed July 14, 1980)..... 16

International Brotherhood of Teamsters v. Daniels,
439 U.S. 551 (1979)..... 24

Marquette National Bank v. First of Omaha Service Corp., 439 U.S. 299 (1978) 25

Miller v. Youakim, 440 U.S. 125 (1979) 25, 35

New York State Department of Social Services v. Dublino, 413 U.S. 405 (1973) 24, 29

Owens v. Roberts, 377 F.Supp. 45 (M.D.Fla. 1974) 29

Philbrook v. Glodgett, 421 U.S. 707 (1975) 35

Power Reactor Development Co. v. International Union of Electrical, Radio and Machine Workers, AFL-CIO, 367 U.S. 396 (1961) 30

Red Lion Broadcasting Co. v. FCC, 395 U.S. 367 (1969) 24

Robinson v. Pratt, CCH Medicare & Medicaid Guide, ¶30,605 (D.Mass. 1980) 11, 26, 32

Rosado v. Wyman, 397 U.S. 397 (1970) 3

Scarpuzza v. Blum, 73 A.D.2d 237, 426 N.Y.S.2d 505 (2d Dept. 1980) 11, 15, 25, 26, 29

Schaak v. Schmidt, 344 F.Supp. 99 (E.D.Wis. 1971) 26

Schultz v. Noot, Civ. No. 4-79-334 (D.Minn. 1979) 26

Townsend v. Swank, 404 U.S. 282 (1971) 3

Udina v. Walsh, 440 F.Supp. 1151 (E.D.Mo. 1977) 29

West v. Cole, 390 F.Supp. 91 (N.D.Miss. 1975) 4

Winter v. Quern,
490 F.Supp. 788 (N.D.Ill. 1980) 26

Winter v. Trainor,
CCH Medicare & Medicaid Guide, ¶28,151
(N.D.Ill. 1977) 26

Wong v. Brian,
CCH Medicare & Medicaid Guide, ¶26,605
(Cal.Ct.Ap. 1972) 26

Statutes:

20 U.S.C. §3508 3
28 U.S.C. §1254(1) 2
42 U.S.C. §1381 *et seq.* 4
42 U.S.C. §1382(e)(1)(B) 33
42 U.S.C. §1382b(b) 11,15
42 U.S.C. §1395 *et seq.* 34
42 U.S.C. §1395d(a)(2) 34
42 U.S.C. §1396 *et seq.* 2
42 U.S.C. §1396a(a)(10) 2
42 U.S.C. §1396a(a)(10)(A) 4, 12, 16, 23
42 U.S.C. §1396a(a)(10)(B) 18
42 U.S.C. §1396a(a)(10)(C) 5, 10, 18
42 U.S.C. §1396a(a)(10)(C)(i) 12, 18, 22, 23
42 U.S.C. §1396a(a)(17) 2, 12, 19
42 U.S.C. §1396a(a)(18) 6
42 U.S.C. §1396a(b) 3
42 U.S.C. §1396a(f) 4
42 U.S.C. §1396b 3
42 U.S.C. §1396c 3
42 U.S.C. §1396h(a) 14, 30
Pub.L. No. 92-603, 86 Stat. 1465 4

Pub.L. No. 93-233, §13(a)(3), 87 Stat. 960 ..... 4, 18
Pub.L. No. 96-499 28
California Welfare & Institutions Code
§14005.7 5
§14015 2,6
§14051 5

Regulations:

20 C.F.R. §416.231(a)(2) 33
42 C.F.R. §435.4 4,5
42 C.F.R. §435.120 4
42 C.F.R. §435.120(b) 12, 16
42 C.F.R. §435.121 4
42 C.F.R. §435.301 5
42 C.F.R. §435.401(c) 2, 12-13, 21
42 C.F.R. §435.812 21
42 C.F.R. §435.831(a) 21
42 C.F.R. §435.840 21
42 C.F.R. §448.2(b)(2) 21
45 C.F.R. §201.6(c) 3, 24
45 C.F.R. §248.2(b)(2) 21
Title 22 California Administrative Code
§50203 5
§50408(b) 6
§50409 ..... 2, 6, 7
§50409(b)(2) 32, 34
§50409(b)(2)(A) 6, 32
§50409(b)(2)(B) 7, 32
§50411(a) 2, 7, 8
§50418 6
§50420 6
§§50425-50489 6
§50425(a)(4) 6, 8

Miscellaneous:

39 Fed.Reg. 9515 (1974)..... 21
42 Fed.Reg. 2684 (1977)..... 22
42 Fed.Reg. 33071, 33093 (1977)..... 23
42 Fed.Reg. 52827 (1977)..... 21
43 Fed.Reg. 45176 (1978)..... 21
43 Fed.Reg. 45204 (1978)..... 21
44 Fed.Reg. 10553 (1979)..... 3, 30
126 Cong.Rec. H11687-H11703 (daily ed., Dec. 3, 1980)..... 28
126 Cong.Rec. S15335-S15355 (daily ed., Dec. 3, 1980)..... 28
Comm.Pub. No. 96-245, 96th Cong., 2d Sess. (1980)..... 34
HCFA Regional Office Manual, Part 6, Medicaid Guidelines Transmittal No. 31 (June 19, 1979), reprinted in CCH Medicare & Medicaid Guide, ¶30,392..... 23
H.R.Rep. No. 96-589, part 2, 96th Cong., 2d Sess. ('1980)..... 13, 28
HHS Action Transmittal No. 80-75 (Oct., 1980)..... 3
Senate Finance Committee Press Release No. H-18 (March 22, 1979), reprinted in CCH Medicare & Medicaid Guide, ¶29,592..... 28
S.Rep. No. 404, 89th Cong., 1st Sess. (1965), reprinted in [1965] U.S. Code Cong. & Admin. News, 1943..... 12, 17, 18, 20
S.Rep. No. 95-1111, 95th Cong. 2d Sess. (1978)..... 28
S.Rep. No. 96-471, 96th Cong., 1st Sess. (1979)..... 28
Social Security Administration Claims Manual, §12507(a)..... 2, 11, 15

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OPINIONS BELOW

The opinion of the Court of Appeals (J.A. 56) is reported at 622 F.2d 1304. The district court's unreported Findings of Fact and Conclusions of Law of May 10, 1979 appear in the Joint Appendix, at 47.

JURISDICTION

The Court of Appeals filed its Opinion on May 14, 1980. A timely petition for rehearing and rehearing *en banc* was denied on July 30, 1980, with the petition for certiorari filed on August 27, 1980. The Court granted the petition, limited to the Supremacy Clause argument, on November 3, 1980 (J.A. 75). Jurisdiction is invoked under 28 U.S.C. §1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

The relevant federal provisions are 42 U.S.C. §§1396a(a)(10) and (17); 42 C.F.R. §435.401(c)(2); and the Social Security Administration Claims Manual, §12507(a). The relevant state provisions are California Welf. & Inst. C. §14015, and 22 Cal.Admin.C. §§50409, 50411(a). The pertinent texts of these provisions are set out verbatim in Appendix D to the petition for certiorari.

STATEMENT OF THE CASE

1. California participates in the Medical Assistance ("Medicaid") program, which was added by Title XIX of the Social Security Act, 79 Stat. 343, as amended, 42 U.S.C. §1396 *et seq.* The court below summarized the basic obligations inherent in this participation:

> "This cooperative federal-state program is designed to provide medical assistance to certain classes of individuals who are in need of such assistance. Although

> states are not required to participate, if they choose to do so they must develop a plan which conforms to the federal guidelines. 42 U.S.C. §1396a(b) . . . . After a state's plan is approved by the Secretary of [Health and Human Services], the state then receives reimbursement for a portion of the funds which are expended. 42 U.S.C. §1396." *Dawson v. Myers,* 622 F.2d 1304, 1307 (9th Cir. 1980) (J.A. 57). See also, *e.g., Harris v. McRae,* ____ U.S. ____, 100 S.Ct. 2671, 2680 (1980).

Under the formula, California has received, and will continue to receive, fifty per cent of its costs as reimbursement from the federal government. 42 U.S.C. §1396b; 44 Fed.Reg. 10553 (1979); HHS Action Transmittal No. 80-75 (Oct., 1980).

Implicit in participation in the federal Medicaid program is that a state must comply with controlling federal law and regulations. *Harris v. McRae, supra,* 100 S.Ct., at 2680; *Fabula v. Buck,* 598 F.2d 869, 870-871 (4th Cir. 1979); see also, *e.g., Townsend v. Swank,* 404 U.S. 282, 286 (1971). In theory, the Secretary of the Department of Health and Human Services ("HHS")[1] can deprive the state of its matching funds, if, after a compliance hearing, it is determined that the state fails to meet federal requirements, 42 U.S.C. §1396c; see *Rosado v. Wyman,* 397 U.S. 397, 406 n.8 (1970); that drastic sanction, however, is rarely, if ever, invoked. Instead, the Secretary attempts to correct state failures through informal discussion and negotiation. 45 C.F.R. §201.6(c).

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[1]Although many of the policies discussed in this brief were developed by HHS' predecessor, the Department of Health, Education and Welfare ("HEW"), see 20 U.S.C. §3508, references herein will be limited to the designation "HHS". It should be assumed that that expression necessarily refers to "HEW", where chronologically applicable.

Within the confines of the federal statute and regulations, a state has considerable latitude in structuring and administering its program. It is required to provide assistance to the so-called "categorically needy", who are those individuals meeting both a definition of either age, blindness, disability or childhood dependency, and the financial eligibility conditions of the relevant cash assistance program. 42 C.F.R. §435.4. Even so, a state has flexibility in defining the financial eligibility conditions of the categorically needy aged, blind and disabled. It can use the same conditions as are applicable to recipients of Supplemental Security Income ("SSI"), 42 U.S.C. §1381 *et seq.*, the federally-administered and -funded welfare program for the indigent aged, blind and disabled. 42 U.S.C. §1396a(a)(10)(A); 42 C.F.R. §435.120; see *Harris v. McRae, supra,* 100 S.Ct., at 2680 & n.1; *Dawson v. Myers, supra,* 622 F.2d, at 1307 (J.A. 57-58).[2] Alternatively, it can employ more restrictive eligibility conditions, as long as they are no more restrictive than those validly in effect in the state on January 1, 1972. 42 U.S.C. §1396a(f); 42 C.F.R. §435.121; see *Gray Panthers v. Administrator, supra,* 629 F.2d, at 182; *West v. Cole,* 390 F.Supp. 91, 95-99 & nn. 5,6 (N.D.Miss. 1975). Like most states, California did not originally select this

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[2]The SSI program was created in 1972, and went into effect on January 1, 1974. Pub.L. No. 92-603, 86 Stat. 1465. Congress then amended the Medicaid statute to require that Medicaid be automatically available to SSI recipients, as it had been to the recipients of the state-administered cash assistance programs for the aged, blind, and disabled which preceded it. Pub.L. No. 93-233, §13(a)(3), 87 Stat. 960 (1973). See *Gray Panthers v. Administrator, Health Care Financing Administration,* 629 F.2d 180, 182 & n.3 (D.C.Cir. 1980), *pet. for cert. pending sub nom. Harris v. Gray Panthers,* No. 80-756 (filed Nov. 10, 1980); *Caldwell v. Blum,* 621 F.2d 491, 496-497 (2d Cir. 1980), *pet. for cert. pending* No. 79-2034 (filed June 24, 1980).

option, nor has it changed its position; under its state plan, it is therefore required to provide Medicaid pursuant to the SSI eligibility conditions. *Dawson v. Myers,* 622 F.2d, at 1307 n.2 (J.A. 58). Because of its application of the SSI eligibility conditions, California is informally known as an "SSI state".[3]

Regardless of the eligibility conditions that it selects for the categorically needy, a state also has the option of providing Medicaid to an additional class of individuals, known as the "medically needy". They also must meet one of the applicable categorical definitions (i.e., age, blindness, disability, or childhood dependency). They are distinguished from the categorically needy by the fact that their gross income or resources are above the cash assistance levels for eligibility. 42 U.S.C. §1396a(a)(10)(C); 42 C.F.R. §435.4; *Beal v. Doe,* 432 U.S. 438, 440 & n.1 (1977); *Dawson v. Myers,* 622 F.2d, at 1307 & n.3 (J.A. 58); *Friedman v. Berger,* 547 F.2d 724, 726 (2d Cir. 1976), *cert. denied* 430 U.S. 984 (1977). They become eligible after incurring medical expenses which reduce their available income below a prescribed level. 42 C.F.R. §435.301; *Dawson v. Myers,* 622 F.2d, at 1307 (J.A. 58). California has opted to extend Medicaid eligibility to the medically needy. Cal.Welf. & Inst.C. §§14005.7, 14051; 22 Cal.Admin.C. §50203; *Dawson v. Myers,* 622 F.2d, at 1307 (J.A. 58).

By statute and regulation, California has implemented its participation in the federal Medicaid program. For what is popularly known as "Medi-Cal", the state has established eligibility standards for participants. These provide, *inter*

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[3]Those choosing the more restrictive approach are generally called "209(b)" or "1972 option" states. See *Gray Panthers v. Administrator, supra,* 629 F.2d, at 182 & n.2.

alia, that the assets of an individual must not be valued over $1500. 22 Cal.Admin.C. §50420. An individual's home and certain other properties, however, are exempt from the resource calculations. 22 Cal.Admin.C. §§50418, 50425-50489. Moreover, even if the applicant or recipient herself resides in a long-term care facility, the home remains exempt for purposes of the resource determination as long as a spouse or other dependent continues to live there. 22 Cal.Admin.C. §50425(a)(4). Furthermore, although no state law has been found to support this practice, the Ninth Circuit has stated that California may recover the cost of medical assistance from an individual's estate after her death. *Dawson v. Myers,* 622 F.2d, at 1308 (J.A. 60); see 42 U.S.C. §1396a(a)(18). This mechanism would apparently be available regardless of whether the property is an exempt resource. See *Fabula v. Buck, supra,* 598 F.2d, at 871.

California also has adopted a "transfer of assets" rule. Cal.Welf. & Inst.C. §14015. It is applicable only to the medically needy, and operates to "prevent[ ] persons from qualifying . . . if they have transferred assets for less than fair consideration within two years prior to their application for assistance." *Dawson v. Myers,* 622 F.2d, at 1307-1308 (J.A. 58-60); see 22 Cal.Admin.C. §50408(b). The fact of a transfer for less than valuable consideration creates a presumption that the transfer was effected in order to obtain eligibility. 22 Cal.Admin.C. §50409. The individual, in theory, is permitted to overcome the presumption, but the "declaration of another purpose, such as to avoid probate, by itself, shall not be sufficient to overcome the presumption." *Id.,* §50409(b)(2)(A). Moreover, a demonstration that the applicant "did not have specific knowledge of the availability or benefits of the Medi-Cal program is not sufficient to overcome the presumption." *Id.,*

§50409(b)(2)(B); see *Dawson v. Myers*, 622 F.2d, at 1308 n.5 (J.A. 60). The failure to overcome the presumption results in a denial of eligibility for an unspecified period of time which reflects the actual value of the transferred asset, the estimated cost of care, and the value received for the asset. 22 Cal.Admin.C. §50411.[4]

2. Antonia Beltran is now 88 years old and is expected to require convalescent care for the rest of her life. On February 23, 1977, she and her husband, Leonard, grant-deeded a plot of land in East Los Angeles with two houses on it to their three children. They were living in one of the houses, and they continued to do so after the transfer; one of the children and his family live in the other. Their reason for transferring the property was a long-standing intention to give it to their children when they were no longer capable of taking care of it. Neither of the Beltrans had any knowledge of the resource rules of the Medi-Cal program, nor, at the time, had either one of them sought or obtained Medicaid coverage (R., Tab 14, p.2).[5]

In May, 1977, Antonia Beltran was forced to enter a hospital. When she returned home, a nurse who was helping to care for her arranged an application to California's In-Home Supportive Services program, which provided her with home chore services. At the same time, she and her

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[4]Thus, a transferor who applies more than two years after the date of the transfer will not be subject to section 50409. But an application during that two-year period triggers the presumption and can result in a period of ineligibility substantially greater than two years.

[5]The Record prepared below does not contain consecutively numbered pages, but, rather, utilizes consecutively numbered "Tabs", each of which retains its own pagination. Thus, all references to the Record will be to the appropriate "Tab", and to the page or exhibit within the cited "Tab".

husband were found eligible for the Medi-Cal program. On March 20, 1978, however, she was forced by increasing ill health to move from their house into a nursing home. She required then, and is expected to continue to require for the indefinite future, skilled nursing care. She remained covered by Medi-Cal through August, 1978, when her coverage was terminated. Her husband, however, remained covered. (R., Tab 14, p. 2-3.)[6]

She re-applied on October 27, 1978, but this application was denied on January 8, 1979, specifically because of the February, 1977 transfer of property. (J.A. 49.) The "Notice of Action" informed her that her period of ineligibility would be 885 months, which is slightly over 71 years. (J.A. 6-7, 40; R., Tab 14, Ex. 4.)[7]

Mrs. Beltran's husband, Leonard, continued to live on the property which they had transferred. Because he resided there, the house would have remained an exempt resource for purposes of determining Mrs. Beltran's medically needy eligibility had it not been given away. 22 Cal.Admin.C. §50425(a)(4). Its exempt status, however, did not preclude application of the transfer rule. Moreover, the fact that Mrs. Beltran was not ill when they transferred the property, and the fact that they were not aware of the relevant eligibility conditions at that time, were not considered sufficient to overcome the presumption.

Mrs. Beltran's sole source of income is Social Security

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[6]As near as can be determined, her eligibility for Medi-Cal during this period of May, 1977 through August, 1978, was established without regard to the transfer of property.

[7]Although the record below cannot reflect it, she applied again this year, and was found eligible for Medi-Cal, effective from March 1, 1980. This determination of eligibility was based on a recalculation under the formula set out in 22 Cal.Admin.C. §50411.

benefits. When the summary judgment motion was filed, her monthly check was for $219.80. (R., Tab 14, p. 4.) She paid most of this amount to the nursing facility, but was allowed to keep $45.00 per month for personal needs. Until the redetermination of eligibility, her children paid some of the remaining cost of nursing home care, but a substantial portion remained unpaid (R., Tab 14, p. 4). For the period of ineligibility from September, 1978 through February, 1980, her unpaid bills to the nursing home amounted to nearly $15,000.[8] It is undisputed that, except for appliction of the transfer rule, she would have been found eligible at all relevant times for California's medically needy program, which would have been responsible for the full cost of her care. *Dawson v. Myers,* 622 F.2d, at 1308-1309 (J.A. 61).

3. At the time that Antonia Beltran was denied on re-application in January, 1979, a direct challenge to the transfer rule was then pending in the Central District of California. It had been filed by Rossye Dawson, who had also been denied Medicaid coverage under California's transfer of assets rule. (R. 48.) Antonia Beltran and another individual with the same problem, Enosinsio Manahan, moved to intervene; their complaint-in-intervention was ordered filed on February 26, 1979 (J.A. 2). Beltran and Manahan, like Rossye Dawson, sought declaratory and injunctive relief on behalf of themselves and similarly situated Californians. They alleged that the transfer rule violated federal statutory requirements and Constitutional guarantees. Specifically, they sought to enjoin and invalidate the state's policy of denying or terminating Medi-Cal benefits to those medically needy applicants who had

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[8]The Record, which reflects only the period up to the filing of plaintiffs' summary judgment motion, indicates that by early 1979, her unpaid bills to the nursing home were in excess of $4000 (R., Tab 14, p. 4).

allegedly transferred assets for less than full consideration (J.A. 11).

On May 10, 1979, the district judge granted the motion for class certification (J.A. 45). On the same day, he denied plaintiff's motion for summary judgment, and granted defendants' (J.A. 54-55).[9] The district judge agreed with plaintiffs' contention that a state could not apply more restrictive eligibility conditions to the medically needy than to the categorically needy, but he held that a transfer of assets rule was a "collateral restriction" and a "procedural regulation", not a "substantive eligibility requirement", and that therefore the requirement of equal treatment of the categorically and medically needy was inapplicable (J.A. 51-52).

On appeal, the Ninth Circuit panel agreed with the result reached by the district court, but for different reasons. The court specifically rejected the lower court's characterization of the transfer rule, terming it "a substantive eligibility requirement." *Dawson v. Myers,* 622 F.2d, at 1310 (J.A. 63-64). But the panel concluded that the applicable portion of the Medicaid statute, the so-called "comparability" requirement, 42 U.S.C. § 1396a(a)(10)(C), did not require equal treatment of the two groups of Medicaid applicants. *Id.,* at 1310-1312 (J.A. 64-67).

In doing so, the court effectively held that HHS supported this analysis, id., at 1311 (J.A. 65-66), despite the fact that that agency had started on several occasions that transfer rules could not be applied to the medically needy aged, blind, and disabled in SSI states. (R., Tab 13, Ex. E, F.) Indeed, by letter of September 29, 1978, HHS had informed defendant

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[9]Antonia Beltran and Enosinsio Manahan were the class representatives, as Rossye Dawson had died. *Dawson v. Myers,* 622 F.2d, at 1308 (J.A. 60).

Myers that the state's transfer rule violated federal law (R., Tab 25, Ex. A).

Plaintiffs sought a rehearing, and were supported by HHS, which lodged an amicus brief explicitly contradicting the Court of Appeals' analysis. The Court rejected the request for a rehearing and refused to permit the filing of the HHS amicus brief. (That order is attached as App. C to the Petition for Writ of Certiorari.) By that time, two federal appellate courts, one state appellate court, and two federal district courts had all held, in virtually identical challenges to transfer rules applied against the medically needy in SSI states, that the comparability provisions of the Medicaid statute forbade the use of such rules.[10] In light of the Ninth Circuit's deviation from case authority on the specific issue of this case, and its digression from numerous other decisions upholding comparable treatment of the categorically and medically needy, plaintiff Beltran sought review of that decision.[11]

SUMMARY OF ARGUMENT

A. Aged, blind, and disabled individuals may divest themselves of assets in order to obtain eligibility for SSI benefits. The statute, 42 U.S.C. §1382b(b), and the Social Security Administration Claims Manual, §12507(a),

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[10]*Caldwell v. Blum,* 621 F.2d 491 (2d Cir. 1980), *aff'd* CCH Medicare & Medicaid Guide, ¶30,093 (N.D.N.Y. 1979) (classwide preliminary injunction); *Fabula v. Buck,* 598 F.2d 869 (4th Cir. 1979), *rev'd* 463 F.Supp. 830 (D.Md. 1978); *Robinson v. Pratt,* CCH Medicare & Medicaid Guide, ¶30,605 (D.Mass. 1980); *Scarpuzza v. Blum,* 73 A.D.2d 237, 426 N.Y.S.2d 505 (2d Dept. 1980).

[11]Enosinsio Manahan had died during the pendency of the appeal.

explicitly allow this. In addition, the Medicaid statute establishes that all SSI recipients are automatically eligible for Medicaid as "categorically needy". 42 U.S.C. §1396a(a)(10)(A). These two factors lead to the requirement that, in "SSI" states, categorically needy Medicaid eligibility must be determined without regard to any prior transfer of assets. The regulations reflect this result. 42 C.F.R. §435.120(b).

B. The required equal treatment of the categorically and medically needy leads necesarily to the conclusion that states also cannot apply transfer of assets prohibitions to determine medically needy eligibility.

1. In establishing the Medicaid program, Congress made significant progress in offering states the option of extending benefits to the medically needy whose indigency is caused by high medical costs. A cornerstone of this development was the recognition that, once incurred medical expenses were taken into consideration, the categorically and medically needy were equally impoverished. Consequently, Congress determined to apply the same eligibility conditions to both groups. The statute reflects this intention by requiring eligibility to be determined by "comparable standards", 42 U.S.C. §§1396a(a)(10)(C)(i), 1396a(a)(17), and the legislative history reiterates the congressional recognition for equal treatment of the two groups. See, *e.g.*, S.Rep. No. 404, 89th Cong., 1st Sess. (1965), reprinted in [1965] U.S. Code Cong. & Admin. News, 1943, 2017-2019.

2. In carrying out this goal, the responsible federal agency, HHS, has repeatedly and consistently required states not to discriminate against the medically needy. The regulation applicable to this situation, 42 C.F.R.

§435.401(c), specifically forbids states to use eligibility conditions "more restrictive than those used under SSI . . . ." HHS has expressed its position on comparability in other situations as well. Also, HHS specifically informed California that its transfer of assets rule violated the federal comparability requirements because it was imposed only against the medically needy. Because the HHS evaluation of this issue is long-standing and consistent, it is entitled to considerable deference from the courts.

3. Indeed, while considering various Medicaid issues, the lower courts have regularly agreed that the statute precludes treating the medically needy more restrictively than the categorically needy. On the specific issue of transfer of assets, the Second and Fourth Circuits, a state appellate court in New York, and two federal district courts have all disagreed with the Ninth Circuit and concluded that the comparability requirement precluded states from applying transfer of assets rules to the medically needy. The courts noted, as have Congress and HHS, that there was no rationale for treating one group of indigents differently than another.

4. Furthermore, in reports accompanying several bills proposed over the last three years, Congress has explicitly stated that "present law" forbids states from applying transfer of assets restrictions. See, *e.g.*, H.R.Rep. No. 96-589, part 2, 96th Cong., 2d Sess., 76 (1980). None of these bills has passed. These subsequent legislative observations offer additional confirmation as to existing federal law on this issue.

C. The courts' repeated invalidation of transfer rules has not left the states unprotected. They are permitted to deny Medicaid coverage for up to a year to an applicant who has

attempted to abuse the system, such as by divesting herself of assets in order to obtain eligibility. 42 U.S.C. §1396h(a). Congress' affirmative action in passing this provision, coupled with its repeated decisions not to enact other legislation, indicates that it views the existing approach as the better policy. Examples of how transfer rules unjustly deprive needy people of coverage back this Congressional determination. While many elderly people transfer assets for entirely innocent reasons, the states have repeatedly failed to exercise restraint in applying their divestment provisions. For all of these reasons, the present federal policy is entirely appropriate.

D. That the Ninth Circuit disagrees with this policy is not a sufficient reason for it to substitute its judgment for that of Congress and HHS. Similarly, California may not operate unilaterally. The state does have legitimate options, though. it can attempt to change the federal law. it also may alter its position within the existing Medicaid structure, such as by rejecting the SSI eligibility conditions in favor of "209(b)" status. Dissatisfaction with existing federal policy, however, does not give California the freedom to establish its own eligibility conditions. Its participation in the federal Medicaid scheme and its considerable reimbursement from the federal government require California, like all states, to conform to federal law. That law precludes states from using transfer of assets rules in SSI states.

ARGUMENT

SINCE THE SSI STATUTE PROHIBITS APPLYING TRANSFER OF ASSETS RULES TO SSI APPLICANTS, STATES ARE FORBIDDEN TO CONSIDR TRANSFERS IN DETERMINING ELIGIBILITY OF THE MEDICALLY NEEDY IN "SSI" STATES

A. Transfer rules cannot be applied in SSI states to determine eligiblity for the categorically needy aged, blind and disabled.

It is indisputable that an SSI applicant is permitted to divest herself of assets in order to become eligible for SSI payments. *Dawson v. Myers,* 622 F.2d, at 1310 (J.A. 63); *Caldwell v. Blum,* 621 F.2d, at 494-495; *Fabula v. Buck,* 598 F.2d, at 873; *Scarpuzza v. Blum,* 426 N.Y.S.2d, at 512. The statute specifically permits the Secretary to prescribe the rules applicable to the disposition of assets. 42 U.S.C. § 1382b(b). The administrative interpretation of this statute leaves no doubt that a valid transfer of assets, regardless of the consideration received, is not relevant to the determination of SSI eligibility.

> "The valid disposal or transfer, as by sale or gift, of a resource prior to the filing of an SSI program application, does not preclude eligibility for payment, even though retention of the resource would have placed an individual's or couple's resources over the applicable limit. This is true with respect to cash and real or personal property and also true though the resource may have been given as a gift or sold for less than its market value to a relative or friend." Social Security Administration Claims Manual, § 12507(a) (App. D to Petition for Certiorari, at 37).

Indeed, the Manual expressly recognizes that the effort to divest may be intended "for the purpose of being within the applicable limits. . . ." *Ibid.* In effect, as long as the transfer is valid, it is of no consequence for SSI eligibility why the property is transferred.

It then automatically follows that no transfer rule may be applied to determine the Medicaid eligibility of SSI applicants and recipients. This is so because, as has been previously noted, the SSI states are required to determine Medicaid eligibility for the categorically needy using the same rules as are employed in determining SSI eligibility. The Medicaid statute requires this identical treatment, as it demands that all those eligible for SSI be covered under Medicaid. 42 U.S.C. § 1396a(a)(10)(A). The courts agree that this is the statute's correct interpretation.[12] And, lest any doubt exist, the regulations require states to provide Medicaid to those SSI recipients who have disposed of assets. 42 C.F.R. § 435.120(b).

Neither the defendants below, nor any of the courts which have considered the transfer issue, have suggested otherwise. The point of departure, therefore, must be that California may not apply a transfer of assets rule to its aged, blind, and disabled applicants for categorically needy Medicaid coverage.

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[12]See, *e.g., Harris v. McRae, supra,* 100 S.Ct., at 2680 n.1; *Beal v. Doe, supra,* 432 U.S., at 440 n.1; *Blum v. Caldwell,* — U.S. — , 100 S.Ct. 1635, 1637 (Mr. Justice Marshall, in chambers, 1980); *Caldwell v. Blum,* 621 F.2d, at 494. But see *Herweg v. Ray,* 619 F.2d 1265, 1272-1274 (8th Cir. 1980), *pet. for cert. pending* No. 80-60 (filed July 14, 1980) (evenly divided *en banc* court upholding district court determination that Iowa, an SSI state, need not follow certain HHS Medicaid regulations premised on SSI rules).

B. The "comparability" requirements of the Medicaid statute preclude applying more restrictive rules to the medically needy than to the categorically needy.

1. One of the most significant advances in Title XIX was the effort to extend coverage to those whose poverty was caused by high medical costs. States were given the option of providing medical care not only to those who were indigent by any standard, but also to those who were medically indigent, that is, forced to choose between medical care and other necessities.

To accomplish this goal, Congress established a flexible system for determining eligibility. It created a "spend-down" mechanism, by which the applicant whose gross income and resources were over the eligibility levels became eligible for Medicaid once her actual income and resources had been reduced to the established level of indigency by necessary medical costs. A state had to "be sure that the income of the individual has been measured in terms of both the state's allowance for basic needs and the cost of the medical care he requires." S.Rep.No. 404, 89th Cong., 1st Sess. (1965), reprinted in [1965] U.S. Code Cong. & Admin. News, 1943, 2019 (1965).

Congress logically determined that this group should have their poverty evaluated at the same levels and by the same procedures as did those whose eligibility was established without considering medical costs. Indeed, it would have been extremely cynical to recognize the precarious position of the medically indigent, and then premise their eligibility on standards more restrictive than those applicable to the categorically needy. The legislature's concern that the medically needy be treated no differently than the cate-

gorically needy is reflected in this passage from the Senate Finance Committee report:

> "In no event, however, with respect to either the [medically needy spend-down] provision or that described below with reference to the use of deductibles for certain items of medical service, may a State require the use of income and resources which would bring the individual's income below the amount established as a test of eligibility under the State plan. Such action would reduce the individual below the level determined by the state as necessary for his maintenance." S.Rep.No. 404, 89th Cong., 1st Sess. (1965), reprinted in [1965] U.S. Code Cong. & Admin. News, 1943, 2019.

In short, common sense dictated that if the medically needy were entitled to coverage, states had to recognize that once medical expenses were considered, they were just as impoverished as the categorically needy.

The decision to utilize equivalent eligibility standards is initially reflected in the provision identifying the medically needy. It permits states to provide assistance to

> "all individuals who would, except for income and resources, be eligible . . . to have paid with respect to them supplemental security income benefits and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services. . . ." 42 U.S.C. § 1396a(a)(10)(C)(i).[13]

The provision first identifies the medically needy. They are those who, except for having income or resources over the

[13]This provision was originally codified as 42 U.S.C. § 1396a(a)(10)(B). 79 Stat. 345 (1965). A 1973 amendment, Pub. L. 93-233, § 13(a)(3), 87 Stat. 960, recodified and slightly reworded the provision as 42 U.S.C. § 1396a(a)(10)(C). The spend-down and comparability provisions were not altered.

eligibility levels, would be eligible for cash assistance. Thus, although they meet the categorical definition of age, blindness, or disability, their greater gross income or resources renders them ineligible for cash assistance. The recognition of this similarity between cash assistance recipients and those with income and resources over the cash assistance levels leads to the requirement of comparability in the next section of the provision. As the only difference between the groups is the greater gross income and resources of the medically needy, they become, for all relevant purposes, indistinguishable when those amounts are reduced to the poverty level by medical costs. Consequently, it is appropriate that comparable standards be applied to them.[14]

Congress' concern that one classification of eligibles not be discriminated against is further reflected in the general eligibility section, 42 U.S.C. §1396a(a)(17). It requires states to "include reasonable standards (which shall be comparable for all groups. . . .)" This section thus reinforces the legislative goal that once a group is recognized as eligible for Medicaid, states cannot apply discriminatory standards against it.

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[14]The Ninth Circuit's discussion of this section, 622 F.2d, at 1310-1311 (J.A. 64), is unique in both case law and agency interpretation. While recognizing that the section does extend all of the SSI conditions to the medically needy, the court concludes that the reference is only to non-financial conditions of eligibility. The court states that "[w]ere this not the case, then there would be no distinction between the two groups." *Id.*, at 1310-1311 (J.A. 64). The distinction between the categorically and medically needy, though, is defined by the "except for" clause: the latter have larger gross incomes and resources than the former. If the analysis of the court below were correct, there would be no limits on minimum eligibility conditions imposed by the states on the medically needy.

The discussion of these provisions in the legislative history reiterates the Congressional concern for equality of treatment between the medically and categorically needy. Thus, the Senate Finance Committee Report notes that

> "if a state extends the program to those persons not receiving assistance under titles I, IV, X, XIV, and XVI, the determination of financial eligibility must be on a basis that is comparable as among the people who, except for their income and resources, would be recipients of money for maintenance under the other public assistance programs." S.Rep.No. 404, 89th Cong., 1st Sess. (1965), reprinted in [1965] U.S. Code Cong. & Admin. News, 1943, 2017.

That Report also includes this discussion requiring equal treatment:

> "Another provision is included that requires States to take into account only such income and resources as (determined in accordance with standards prescribed by the Secretary) . . . would not be disregarded (or set aside for future needs) in determining the eligibility for and the amount of the aid or assistance in the form of money payments for any such applicant or recipient under the title of the Social Security Act most appropriately applicable to him." *Id.*, at 2018.

2. Comparability, thus, was an important and much-considered aspect of the Medicaid statute. Congress was generally concerned that states not be permitted to treat one group of eligibles different than another. The statute reflects that concern. The Ninth Circuit has suggested, however, that "comparable standards" may be defined, in effect, to include contradictory eligibility requirements. *Dawson v. Myers,* 622 F.2d, at 1311 (J.A. 64, 65). If any vagueness does not attach to the word "comparable", though, the responsible federal agency has expressly and repeatedly clarified its

meaning. HHS has recognized through the years that Congress sought to avoid discriminatory treatment of the medically needy. The applicable present regulation spells this out simply and conclusively:

> "(c) The [state] agency must not use requirements for determining eligibility for optional coverage groups that are. . .
>
> (2) for aged, blind, or disabled individuals, more restrictive than those used under SSI. . . ."

42 C.F.R. §435.401(c).

The regulations further note that a state may employ *higher* eligibility levels for the medically needy, 42 C.F.R. §§435.812, .840, but it is precluded from using more restrictive conditions.

Section 435.401(c) was first promulgated by HEW in 1974. Although its numbering and wording have changed, the meaning and intent have never been altered.[15] The agency has consistently required that the medically needy not be treated more restrictively than the categorically needy, and regulations relevant to other aspects of comparability further reflect this long-standing policy.[16]

Furthermore, in comments to regulations which sought to

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[15]The original section was 45 C.F.R. §248.2(b) (2). 39 Fed.Reg. 9515 (1974). A renumbering of regulations rendered it 42 C.F.R. §448.2(b) (2). 42 Fed.Reg. 52827 (1977). A year later, it was reworded and recodified in its present form. 43Fed.Reg. 45204 (1978). See *Caldwell,* 621 F.2d, at 497 n.8. Although the wording was altered, HHS specifically noted in its introduction that "[n]o policy changes have been made in the eixsting regulations" and that there were "[n]o substantive changes". 43 Fed.Reg. 45176. This is significant, as there was some confusion arising from the previous wording of the regulation. See *Fabula v. Solomon, supra,* 463 F.Supp., at 836. The 1978 rewording, however, leaves no doubt that states could not use more restrictive eligibility conditions, and this has always been HHS policy.

[16]See, *e.g.,* 42 C.F.R. §§435.812, .831(a), .840.

integrate certain SSI eligibility conditions into state Medicaid standards, HHS explained its comprehension of the statutory requirement for no more stringent eligibility conditions for the medically needy:

> "Section 1902a(10)(C)(i)[42 U.S.C. §1396a(a)(10)(C)(i)] goes on to state that where a State covers other aged, blind and disabled persons all SSI eligibility criteria must be applied '. . . except for income and resources. . .'. This means that while a state might use more generous maintenance amounts in determining financial eligibility . . ., all other SSI eligibility criteria are to be used.
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> * * *
>
> [A]ll aged, blind and disabled persons applying in States covering all SSI eligibles must have their eligibility determined using all SSI eligibility rules except for — and only except for — higher dollar amounts for income and resource eligibility levels." 42 Fed. Reg. 2684 (1977).

This discussion provides a comprehensive explanation of the proper interpretation of the statute. The medically needy can, if a state so desires, have higher eligibility levels, but the state must, at a minimum, set those standards no lower than the SSI levels. A state is forbidden to use more restrictive conditions.

Although those pronouncements would appear clear-cut and not subject to conflicting interpretations, the agency also sent out a specific explanation as to the applicability of these requirements in the divestment context. After reviewing the relevant statutes and regulations, HHS concluded:

> "Since transfer of property restrictions are not imposed under the SSI program, [SSI] states may not deny Medicaid eligibility to aged, blind and disabled persons who have transferred property prior to applying as categorically needy.

* * *

> With respect to the medically needy, [the applicable regulations] require that coverage of the medically needy must correspond to categorically needy coverage available under the state's plan (i.e., eligibility conditions imposed on the medically needy cannot be more restrictive than the conditions for eligibility as categorically needy) . . . . Thus, transfer of property restrictions cannot be imposed on the medically needy unless comparable restrictions are imposed on the categorically needy . . . ." HCFA [Health Care Financing Administration of HHS] Regional Office Manual, Part 6, Medicaid Guidelines, Transmittal No. 31 (June 19, 1979), reprinted in CCH Medicaire & Medicaid Guide, ¶ 30,392.

Perhaps most significant, however, is that the federal agency's view on this matter has been explicitly presented to the defendants. In his letter of September 29, 1978, Lawrence McDonough, the Regional Medicaid Director, who represents the Secretary for the region in which California is located,[17] informed defendant Myers of California's non-compliance:

> "[A] 'transfer of property' restriction may not be imposed upon SSI recipients for purposes of determining Medicaid eligibility since such a restriction is not permitted for SSI eligibility purposes. Accordingly, a State that chooses the above-referenced option would not be fulfilling its obligation to make Medicaid assistance available to all SSI recipients (as required by [42 U.S.C. §1396a(a) (10) (A)] if it imposed a 'transfer of property' restriction. Absent such a restriction on the categorically needy, [42 U.S.C. §1396a(a) (10) (C) (i)] precludes imposition of a 'transfer of property' restriction on the corresponding group of the medically needy in the State's Title XIX program." (R. Tab 25, Ex. A, 21-22.)

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[17]See Statement of Organization, Function, and Delegation of Authority, 42 Fed.Reg. 33071, 33093 (1977).

Similar expressions of non-compliance from Regional Directors were sent to state officials in New York and Michigan, and a further explanation of HHS' position was provided to plaintiffs' attorneys in this case (R. Tab 14, Ex. C, E, F). See *Caldwell,* 621 F.2d, at 495; *Fabula,* 598 F.2d, at 873 n.10; *Scarpuzza,* 426 N.Y.S.2d, at 513 & n.19. Moreover, HHS lodged an amicus brief with the Ninth Circuit supporting plaintiffs' request for a rehearing, in which it restated its agreement with plaintiffs' position. It must therefore be beyond serious dispute that HHS views California's transfer rule as violative of federal law.[18]

Thus, any uncertainty as to the meaning of the comparability provision has been resolved by the responsible federal agency. HHS' approach to this problem has never changed course, and follows that of the courts which have considered it. See, *e.g., Caldwell,* 621 F.2d, at 497 n.8. It is well established that an agency's "consistent, long-standing interpretation of the statute under which it operates is entitled to considerable weight." *International Brotherhood of Teamsters v. Daniels,* 439 U.S. 551, 566 n.20 (1979); *New York State Department of Social Services v. Dublino,* 413 U.S. 405, 421 (1973); *Red Lion Broadcasting Co. v. FCC,* 395 U.S. 367, 381 (1969). This is not an instance in which the agency has published contradictory or unclear positions, or contravened clear Congressional

[18]The Ninth Circuit's attempt to ignore the position of HHS, 622 F.2d, at 1311 (J.A. 66), represents a misperception of how that agency is structured. The Regional Directors speak for the Secretary, not contrary to her. The other courts considering this issue all recognized the significance of the regional determinations. *Caldwell,* 621 F.2d, at 495; *Fabula,* 598 F.2d, at 873 n.10; *Scarpuzza,* 426 N.Y.S.2d, at 513 n.19. Furthermore, the decision to seek compliance without a formal hearing is standard HHS policy. See 45 C.F.R. § 201.6(c). The radical sanction of a termination of funds is rarely employed.

intent. See, *e.g., Esponoza v. Farah Manufacturing Co.,* 414 U.S. 86, 94-95 (1973). Indeed, the agency interpretation directly follows from the provisions enacted by Congress. As the Fourth Circuit succinctly noted when considering the same issue: "[T]hese administrative interpretations are reasonable and consistent with the statute, and are entitled to be followed by the courts." *Fabula v. Buck,* 598 F.2d, at 873. See also *Miller v. Yoakim,* 440 U.S. 125, 144 & n.25 (1979); *Caldwell,* 621 F.2d, 497; *Scarpuzza,* 426 N.Y.S.2d, at 513.

3. HHS' position on comparability is not a unique one. Indeed, the policy which this position effects has long been accepted and implemented by courts around the country. Except for the Ninth Circuit, there is no extant decision which allows for discrimination against the medically needy. The courts have regularly concluded that the statute requires states not to apply more restrictive conditions to the medically needy.

The list of cases which counter the analysis of the Ninth Circuit is itself an indication of the impropriety of that

Court's decision.[19] These decisions, which are concerned with various aspects of comparability between the categorically and medically needy, corroborate HHS' effort to carry out the intent of Congress. They recognize, implicitly and explicitly, that while Congress gave the states the option of including a medically needy program, it did not intend that those states selecting that option would act maliciously towards the medically needy. As one court noted in upholding a federal regulation requiring equal treatment:

> "To discriminate against the self-supporting by requiring them to live on income below the level declared by New York to be necessary for minimal maintenance would do violence to the aims of the Medicaid legislation and common sense . . . [I]t remains deep and

[19] *Caldwell v. Blum,* 621 F.2d 491 (2d Cir. 1980), *aff'd* CCH Medicare & Medicaid Guide ¶ 30,093 (N.D.N.Y. 1979); *Fabula v. Buck,* 598 F.2d 869 (4th Cir. 1979), *rev'g on this point,* 463 F. Supp. 830 (D.Md. 1978); *Greklek v. Toia,* 565 F.2d 1259, 1261 (2d Cir. 1977), *cert. denied sub nom. Blum v. Toomey,* 436 U.S. 962 (1978); *Friedman v. Berger,* 547 F.2d 724, 729 (2d Cir. 1976), *cert. denied* 430 U.S. 984 (1977); *Robinson v. Pratt,* CCH Medicare & Medicaid Guide, ¶ 30,605 (D.Mass. 1980); *Winter v. Quern,* 490 F.Supp. 788, 792-793 (N.D.Ill. 1980), previous opinion on same point *sub nom. Winter v. Trainor,* CCH Medicare & Medicaid Guide, ¶ 28,151 at 10,599 (N.D.Ill. 1977); *Hendrickson v. Noot,* CCH Medicare & Medicaid Guide, ¶ 30,499, at 9920 (D.Minn. 1980); *Dawson v. Beach,* No. 78-2350, Slip Op., at 7 (C.D.Cal. 1979) (J.A. 51); *Schultz v. Noot,* Civ. No. 4-79-334, Slip Op., at 8 (D.Minn. 1979); *Aitchison v. Berger,* 404 F.Supp. 1137, 1149 (S.D.N.Y. 1975), *aff'd without opinion* 538 F.2d 307 (2d Cir.), *cert. denied* 429 U.S. 890 (1976); *Dominquez v. Milliken,* CCH medicare & Medicaid Guide, ¶ 26,633, at 9221 (W.D.Mich. 1973); *Schaak v. Schmidt,* 344 F.Supp. 99, 103-104 (E.D.Wis. 1971); *Scarpuzza v. Blum,* 73 A.D.2d 237, 426 N.Y.S. 505 (2d Dept. 1980); *Wong v. Brian,* CCH Medicare & Medicaid Guide, ¶ 26,605 at 9014-9015 (Cal.Ct.Ap.1972). See also *Blum v. Caldwell, supra,* 100 S.Ct., at 1637.

> familiar in our esteem for individual initiative that we would not deem it acceptable without some particular justification to treat those outrside categorical assistance groups less generously than those within. The questioned regulation . . . reflects this philosophy. No good reason appears . . . for . . . holding it invalid." *Aitchison v. Berger, supra,* 404 F.Supp., at 1149-1150 (footnote omitted).

It is no wonder, then, that the Fourth Circuit could not fathom how Maryland could rationally support a divestment rule applicable only to one class of eligibles: "[W]e question how the transfers made by plaintiffs, which would be expressly permitted under SSI guidelines, can be fraudulent acts under the Medicaid program simply because they are performed by the medically needy rather than by an SSI recipient." *Fabula,* 598 F.2d, at 874 (footnote omitted).

In short, the courts have grasped, regularly and virtually without dissent, that common sense and basic justice require treating these two groups the same. Once the income and resources of the medically needy have been reduced to poverty levels by medical expenditures, there is no rationale for different treatment.

4. Additional support that the interpretation of HHS and the courts is the correct one has been recently and repeatedly provided by Congress. In the last three sessions, several bills have been introduced which would have explicitly authorized states to impose some restrictions on what property could be transferred and when. The proponents of these bills undertook these efforts because of Congress' understanding that such rules were not now permissible, as the legislative histories of these proposals indicate. Thus, the Senate Finance Committee made this observation concerning section 21 of H.R. 5285: "Under present law, States which use the SSI criteria in determining Medicaid eligibility for

the aged, blind, and disabled may not impose transfer of assets restrictions on those applicants . . . ." S.Rep.No. 95-1111, 95th Cong., 2d Sess., 24 (1978).

This bill did not pass, but another one, H.R. 934, was proposed. Again, according to the Senate Report, the suggested prohibition would have allowed states to impose restrictions which they are not now permitted to employ. See S.Rep.No. 96-471, 96th Cong., 1st Sess., 48 (1979), quoted in *Caldwell,* 621 F.2d, at 497 n.6. Senate bills which also would have permitted limited restrictions on divestment, S. 505, §24, and 5.507, §13, were accompanied by similar evaluations. Senate Finance Committee Press Release No. H-18 (March 22, 1979), reprinted in CCH Medicare & Medicaid Guide, ¶ 29,592, at 9813. None of these became law. And, similar legislation was proposed this session, H.R. 4000, §31; it also recognized the existing law on this issue:

> "[S]ince there is no prohibition against transfer of assets in the SSI program under current law, a State which does not restrict eligibility of title XVI [SSI] beneficiaries may not impose such a restriction on Medicaid eligibility for any other aged, blind or disabled person." H.R.Rep.No. 96-589, part 2, 96th Cong., 2d Sess., 76 (1980).[20]

Congress has thus explicitly recognized that its requirement of identical treatment of the categorically and medically needy precludes applying transfer rules to the medically needy. Subsequent Congressional comments tend

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[20]Furthermore, proponents of transfer restrictions included one in each of the reconciliation bills proposed this session. S. 2885, §511; H.R. 7765, §333. Both of these provisions, however, were deleted from the final version by the conferees; that version has been passed and signed into law as the Omnibus Reconciliation Act of 1980, Pub.L. 96-499. See 126 Cong.Rec. H11687-H11703 (daily ed., Dec. 3, 1980); 126 Cong.Rec. §15335-§15355 (daily ed., Dec. 3, 1980).

to confirm apparent legislative intent, *New York State Department of Social Services v. Dublino, supra,* 413 U.S., at 416 n.19; *Banco Nacional de Cuba v. Farr,* 383 F.2d 166, 175 (2d Cir. 1967), *cert. denied* 390 U.S. 956 (1968), and this is especially true where, as here, Congress has repeatedly observed the contemporary state of the law. This is not merely an instance in which legislative intent must be inferred from Congressional inaction, but, rather, one in which a later Congress explicitly recognizes the contribution of a prior Congress. The meaning and import of the statute has thus been fully clarified by present legislators. *Caldwell,* 621 F.2d, at 497-498. For Congress, therefore, as well as for the responsible federal agency and nearly all courts considering the matter, the comparability provisions prohibit states from applying divestment rules against the medically needy in SSI states.

C. The federal prohibition against transfer rules reflects a policy decision that these rules are inappropriate.

In the last five years, courts have repeatedly struck down transfer of assets rules for a variety of reasons.[21] This has taken place in the face of claims that transfer rules are necessary to preserve state resources for those who are "truly" in need. See *Dawson v. Myers,* 622 F.2d, at 1315 (J.A. 72). The Medicaid statute, though, does not leave states at the mercy of unscrupulous individuals, as the states suggest. It provides for both criminal and civil punishment of

[21] *Caldwell; Fabula; Scarpuzza; Caldwell v. Blum* ("*Caldwell II*"), No. 78-CV-569 (N.D.N.Y., Nov. 4, 1980); *Udina v. Walsh,* 440 F.Supp. 1151 (E.D.Mo. 1977); *Buckner v. Maher,* 424 F.Supp. 366 (D.Conn. 1976), *aff'd* 434 U.S. 898 (1977); *Owens v. Roberts,* 377 F.Supp. 45 (M.D.Fla.1974).

recipients who engage in certain activities, including improper divestment to obtain eligibility. 42 U.S.C. §1396h(a); see *Fabula v. Buck,* 598 F.2d, at 874. That provision specifically sets out the sanctions available to the state. After a conviction, the individual may be deprived of Medicaid eligibility for up to a year. In the absence of a conviction, though, Congress has apparently concluded that states may not make their own determination to deprive an eligible individual of benefits. *Id.*, at 874. Since the federal government pays at least half the cost of Medicaid in every state, see 44 Fed. Reg. 10553 (1979), it is appropriate that it prevent states from unilaterally applying biased rules which deny coverage to eligible applicants. The federal measure gives states an appropriate tool, and represents a legislative determination that the less finely tuned state efforts are not permissible.

Congress has now repeatedly failed to enact legislation authorizing states to restrict transfers. It could be contended that this consistent refusal to act is due to factors irrelevant to the pros and cons of transfer rules. Still, when Congress does not respond to a situation regularly brought to its attention and taken into consideration, Congressional acquiescence in the existing law can be inferred. *Power Reactor Development Co. v. International Union of Electrical, Radio and Machine Workers, AFL-CIO,* 367 U.S. 396, 408-409 (1961). Given the considerable harm caused by these rules, and their unjust application, it is apparent that Congress, as a body, has determined that the present federal scheme on this issue is the proper one.

It is not here suggested that abuses donot and will not take place. Those abuses, however, are and can be resolved via the existing mechanism in the Medicaid statute. The method utilized by California, and by other states, cuts much too

broad a path, inevitably denying coverage to far too many of the innocent. The states repeatedly demonstrate an inability to refrain from overreacting to alleged abuses by claimants. While, in theory, it might be possible to distinguish fairly and consistently between innocent transferors and those with questionable motives, in practice, transfer rules are applied too strictly and with no sense of common fairness. A few examples demonstrate the inadequacies of these rules, and indicate why their prohibition is the preferred policy.

The representative plaintiff, Antonia Beltran, was denied eligibility despite a number of factors which strongly suggest that she had no intent to defraud. She was not ill at the time of the transfer. She was 86 years old before she first applied for Medicaid — and then only at the suggestion of a nurse (R. Tab 14, p. 2-3). She was not aware of the eligibility conditions when the property was deeded to her children. (R. Tab 14, p. 2.) She and her husband had intended to give it to them all along, and waited until they themselves were no longer capable of taking care of it. (R. Tab 14, p. 2.) Still, the County of Los Angeles concluded that she had not overcome the presumption, and established an unconscionable period of eligibility.

Enosinsio Manahan, who died while this case was pending before the Court of Appeals, presents a harsher example. In May, 1977, three months after he entered a nursing home, his wife sold their house to pay off various debts. He was not legally competent to participate in the disposition of the property (J.A. 25), but Orange County still found him ineligible because of his community property interest in the proceeds of the sale. The hearing officer who reversed this decision noted that Mr. Manahan's mental condition was such that he "lacked a mental capacity to transact legal business." Proposed Decision (J.A. 25). The

defendants, however, overruled the hearing officer, concluding that he had not overcome the presumption: his wife "acted in his behalf." "[T]he fact that [she] . . . made the transfer of property does not absolve the claimant of this action." Decision of the Director (J.A. 37).

Similar decisions appear to be the rule in California, which is not surprising given the nature of the presumption against the claimant.[22] State heavy-handedness, however, is not limited to California. In Massachusetts, another individual with a severe mental impairment lost Medicaid eligibility when his wife, without his knowledge, gave away money from their joint account. *Robinson v. Pratt, supra,* CCH Medicare & Medicaid Guide, ¶ 30,605, at 10,481-10, 482. Ironically, since his wife was an SSI recipient, she was not disqualified for Medicaid assistance. As the court observed: "Mr. Sweeney's case not only represents a harsh application of the rule, but also dramatically demonstrates the unequal treatment of which the plaintiff complains." *Id.*, at 10,481.

In New York, a long-time recipient of Medicaid and SSI transferred her house to a family member in January, 1978. Because she was an SSI recipient, she continued to receive benefits under both programs. Unfortunately, she was forced

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[22]Once the fact of the transfer is established, the claimant can only overcome the presumption that the transfer was made in order to obtain eligibility by "establishing by objective facts, rather than statement of subjective intent, that this presumption is not correct." 22 Cal.Admin.C. §50409(b) (2). Proof that the applicant transferred in order to avoid probate, or that the applicant had no knowledge of Medi-Cal, are specifically cited as insufficient to overcome the presumption. *Id.*, at §50409(b) (2) (A), (B). With this burden, which effectively precludes an individual from testifying as to her intent, it is the rare person indeed who can demonstrate that she did not set out to obtain eligibility.

to enter a skilled nursing facility the following September, with the result that she lost her SSI eligibility.[23] Of course, once that happened, she lost her categorically needy Medicaid eligibility, and was then denied medically needy coverage because of the tansfer. *Caldwell v. Blum, supra,* CCH Medicare & Medicaid Guide, ¶ 30,093, at 9739. The fact that she was eligible in one context, but not in the other, for precisely the same act, is starkly demonstrative of the irrationality of different treatment.[24]

Examples of this kind do not represent extremes.[25] Indeed, many people, especially the elderly, give away their property, for a variety of reasons. Most have no desire to

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[23]The SSI eligibility level in an institution certified for Medicaid coverage is $25 per month. 42 U.S.C. §1382(e) (1) (B); 20 C.F.R. §416.231(a) (2). Consequently, most nursing home residents are dependent on the medically needy spend-down to be eligible for Medicaid.

[24]These situations further support the Congressional recognition that the categorically and medically needy are two sides of the same coin. An institutionalized individual who is denied Medicaid as medically needy is often forced to move to an uncertified home — if indeed she can find even that. Rossye Dawson, the original plaintiff in this case, had to take this route (R. Tab 2). Because that home is not certified by the state, and is not eligible to receive Medicaid payments, the individual's SSI eligibility level reverts to the normal amount. The claimant is then eligible for SSI, and, of course, is automatically covered by Medicaid. If she tried to move to a certified home, however, the cycle would start again.

[25]See, *e.g., Anson v. Kitchin,* 64 A.D.2d 752, 406 N.Y.S.2d 916 (3d Dept. 1978) (welfare department views payment of outstanding credit card bill, while claimant was in the hospital believing that he was dying, as improper transfer of assets); *Gardner v. Lavine,* 56 A.D.2d 930, 393 N.Y.S.2d 51 (2d Dept. 1977) (welfare department views payment of debt after individual was hospitalized for gunshot wounds as improper transfer even though he had unsuccessfully attempted to pay the debt two years prior to his hospitalization).

defraud the Medicaid program. They seek to avoid probate problems and costs; they may want to give their children an opportunity to use the property immediately, rather than forcing them to wait for their deaths. They may be incapable of taking care of real property, and want to ensure that it does not fall into disrepair. In many, probably most, instances, the elderly person is not even aware of the existence of Medicaid.[26] Yet, under the California regulation, ignorance of the program is not a relevant factor in determining the applicant's intent. 22 Cal.Admin.C. §50409(b)(2). Furthermore, as the examples indicate, however the rules are written, they are inevitably applied in the most restrictive possible manner.

D. While California has many options, its participation in the federal medicaid program precludes it from employing a provision which violates federal law.

Congress has determined that the medically needy should be treated no more restrictively than the categorically needy.

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[26]It is a common mistake, for instance, for the public in general, and the elderly in particular, to confuse the Medicaid and Medicare programs. The latter, Title XVIII of the Social Security Act, 42 U.S.C. §1395 *et seq.*, is a federally-administered insurance program, tied to Social Security taxes. See generally *Mathews v. Diaz*, 426 U.S. 67, 70 n.1 (1976). Although it nominally covers skilled nursing home care, 42 U.S.C. §1395d(a)(2), Medicare is not, in practice, a significant factor in nursing home expenditures. Indeed, a recent Report by the House Select Committee on Aging notes that only 1.5% of nursing home care is paid for out of Medicare funds. Comm.Pub.No. 96-245, 96th Cong., 2d Sess., 22 (1980). But few are aware of this *de facto* noncoverage by medicare, and it is doubtful that many people know that nursing home care will have to be paid for by a state's Medicaid program.

The responsible federal agency has effected this goal with specific regulations and interpretative material, and has consistently followed this position. With the exception of the decision below, the courts have agreed that this is a reasonable and proper interpretation of the law. Later Congresses have explicitly recognized this position, and have not changed it. These factors all strongly favor a decision by this Court to the same effect. *Blue Chip Stamps v. Manor Drug Stores,* 421 U.S. 723, 733 (1975).

By contrast, there is no support for the position of the court below. Its analysis indicates a concern with policy, rather than with established law. While a court is free to express disagreement with the policy that a federal law represents, it may not substitute its preference for that of Congress and the responsible federal agency. " '[I]ssues of legislative policy . . . [are] better addressed to the wisdom of Congress than to the judgment of this Court.' " *Miller v. Youakim, supra,* 440 U.S., at 142 n.21, quoting *Marquette National Bank v. First of Omaha Service Corp.,* 439 U.S. 299, 319 (1978). California, of course, has that ability: if state officials are dissatisfied with a federal law which precludes them from carrying out what they believe is the better policy, then "it is the legislative branch to which appeals for modification must be directed." *Philbrook v. Glodgett,* 421 U.S. 707, 719 (1975).

The state has other options, as well, which are built into the Medicaid program and which therefore are not dependent on the cooperation of federal legislators. It can eliminate its medically needy program at any time. While plaintiff certainly does not favor that approach, it is legally available to the state. Also available, and with less drastic effect on recipients, is a shift in the basis of eligibility for the aged, blind, and disabled to the "209(b)" option. New York,

for instance, has just made this move.[27] "Freeing" itself from the SSI eligibility conditions may provide California with the flexibility which it desires.

In short, California is not forever tied to one set of eligibility standards for its Medi-Cal recipients. The statute has provided the states with various options. The state cannot claim that reversal of the lower court in this case will spell doom for its fiscal position.

The federal law for the SSI states on the transfer of assets issue is well settled. It represents the established and repeated determinations of the federal legislature, the responsible agency, and virtually all reviewing courts. Although California may disagree with that policy, it may not select its own course as long as it continues to participate in the cooperative scheme of Medicaid. It has options, but establishing conditions directly opposite to those of the Social Security Act is not one of them. As long as the state accepts federal funds, it must conform with the requirements of federal law. California's transfer of assets rule conflicts with that law, and should be invalidated.

CONCLUSION

The decision of the Court of Appeals should be reversed.

Respectfully submitted,

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[27]See "*Caldwell II*", *supra*, Slip Op., at 9.